

CHAPTER 3

OUTCOMES AND OBQI (CONTEXT FOR OASIS)

A. WHAT IS SO IMPORTANT ABOUT OUTCOMES?¹

Quality of health care can be examined from three fundamental perspectives. First, we can assess the adequacy of the “inputs” to care such as the care setting, the qualifications of care providers, and the equipment and technical devices used. This is the structural perspective of quality, and the specific measures used to assess quality from this perspective (such as percentage of RNs with bachelor's degrees at a given home care agency) are termed *structural measures* of quality.

Second, we can examine the “throughputs” to care such as specific interventions, comprehensiveness of assessment, and adequacy of care planning. This is the process perspective of quality, and the specific measures used to assess quality from this perspective (such as the frequency of wound assessment for a postsurgical patient) are termed *process measures* of quality.

Third, we can assess “outputs” of care by what happens to the health status of patients as a result of care. This is the outcome perspective of quality. Influencing outcomes is the fundamental reason we provide health care. The specific measures used to assess quality from this perspective (such as whether the surgical wound healed during the care interval) are termed *outcome measures*. The rationale for using outcome measures for quality improvement rests with the aforementioned fact that outcomes are why we provide health care.

In home health care as in other health care areas, outcomes are of increasing interest and importance to many parties. (Outcomes always were important, but it has only recently been possible to adequately measure them.) Payers (such as Medicare, Medicaid, managed care plans, etc.) want to know what they obtain on behalf of their patients for the dollars spent. At the Federal level, outcomes were stressed for home health agency survey and certification in the Omnibus Budget Reconciliation Act of 1987. This emphasis increased with CMS' Medicare Home Health Initiative and is reflected in the current OASIS data collection and data reporting regulations. Accreditation programs, including those operated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Community Health Accreditation Program (CHAP), also are focusing on outcomes. The ORYX performance measurement

¹ Material in this chapter is based on Shaughnessy, P.W. and K.S. Crisler with A. Arnold, J. Beaudry, M. Powell, P. DeVore, D. Hittle, R. Schlenker, A. Kramer, S. Bostrom, and B. Campbell (1995). *Outcome-Based Quality Improvement: A Manual for Home Care Agencies on How to Use Outcomes*. Washington, DC: National Association for Home Care, August.

program within JCAHO, for example, uses outcome measures for performance improvement.

In addition to payers and regulators, consumers and their representatives also are requiring information on outcomes from care providers. Organizations such as the American Association of Retired Persons (AARP) are active in this area. Equally important, home health agencies have always been concerned with measuring their own performance relative to other providers or standards. The home health industry has strongly supported development of an outcome-based approach to quality improvement. This healthy interest in self-analysis at the agency level is at least as strong as the external forces arising from payers, regulators, and consumers.

With respect to OASIS-based outcome measurement and OBQI, it is important to clarify what we mean by patient outcomes.

What outcomes are:

- Outcomes are health status changes between two or more time points, where the term “health status” encompasses physiologic, functional, cognitive, emotional, and behavioral health.
- Outcomes are changes that are intrinsic to the patient.
- Outcomes are positive, negative, or neutral changes in health status.
- Outcomes are changes that result from care provided, or natural progression of disease and disability, or both.

According to these statements, an outcome is a health status change that occurs over time, where the change is intrinsic to the patient. Thus, a change in the patient's environment, such as the provision of a walker or handrails in the patient's residence, is not considered an outcome according to this definition—such changes are services or processes of care. Because the nature of the change can be positive, negative, or neutral, the actual change in patient health status can correspond to improvement, decline, or stabilization (i.e., no change) in patient condition. The definition of an outcome does not include a presumed direction; therefore, any deviation (or nondeviation) in health status between the initial time point and the follow-up time point constitutes an outcome.

Change in health status over a time interval during which care is provided can occur either as a result of the care provided or the natural progression of disease and disability. The challenge in outcome analysis is to attempt to somehow separate changes due to care from those due to natural progression. Statistical risk adjustment refers to a collection of analysis methods designed to separate the relationships of outcomes with care provided from the relationship of outcomes with natural progression of disease and disability, which is critical to accurate outcome analysis. One of the major purposes of OASIS is to provide data items needed for risk adjustment. In essence, the general intent of risk adjustment is to compensate or adjust for differences in case mix or risk factors (between agency and a comparison sample) that should be taken into consideration if outcomes are to be compared validly.

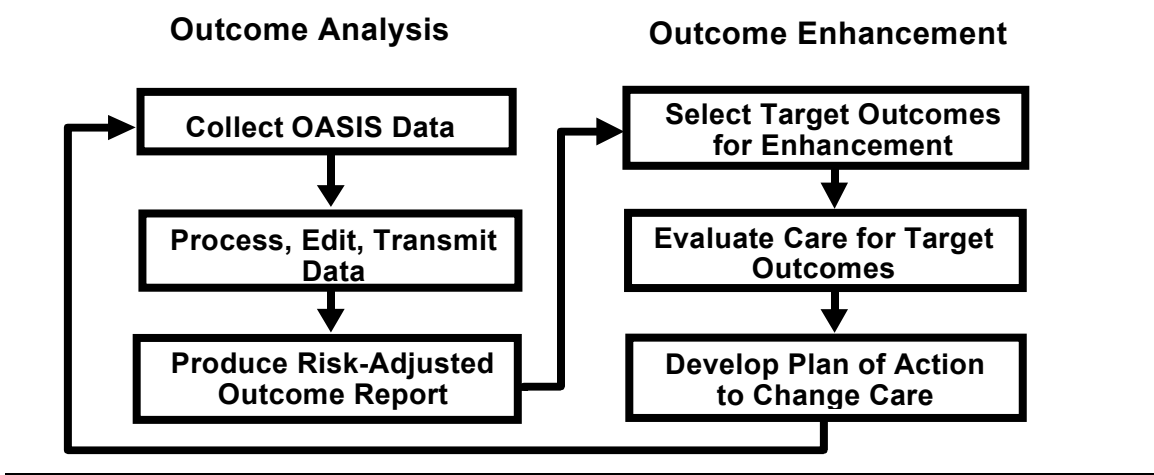
Assessments, care plans, clinical pathways, costs, and utilization of home care services have erroneously been labeled “outcomes” by various parties, creating considerable confusion. The confusion is due largely to two factors. First, as the outcomes movement has grown and become fairly pervasive, an almost inherent need has emerged to place a number of topics under the rubric of outcomes that simply do not belong there. The second factor is related to this. At times, those who promote outcomes, give presentations on topics related to outcomes, coordinate QI programs, or write on such topics, have not always been clear on precisely what they mean by outcomes. Because of a rather human tendency to relabel older or more traditional ideas and methods within the context of a new or novel movement, care planning, treatment regimens, cost, and utilization have been called outcomes at times. They are *not*. OBQI is premised on a clear and practical definition of outcomes as changes in patient health status between two or more time points.

B. WHAT IS OBQI?

Although this manual focuses on implementing OASIS data collection, it is important to remember that the OASIS data items and OASIS data do not represent an end in themselves. Rather, they are the means to achieve outcome measurement and OBQI. Appendix A to this manual contains a glossary of terms related to OBQI. To briefly summarize the OBQI approach, it is fundamentally a two-stage process as shown in Figure 3.1. The first stage is outcome analysis. For the outcome analysis to be conducted for a given agency, it is necessary to collect uniform data (i.e., OASIS data) for all patients in the agency — or those patients with conditions of interest. The result of the first stage is an agency-level report showing the agency's present performance in terms of patient outcomes relative to a national sample of home care patients. This is the first outcome report which an agency receives. The second, and subsequent, outcome reports contain comparisons of an agency's present performance in terms of patient outcomes relative to

the preceding time period for the agency and relative to a national sample of home care patients. These outcome comparisons constitute the outcome analysis portion of OBQI. This first stage should incorporate risk adjustment through grouping or statistical methods, as appropriate. As noted earlier, risk adjustment refers to the process of compensating or controlling for the potential influence of risk factors or case mix variables that can affect outcomes.

FIGURE 3.1: TWO-STAGE OBQI FRAMEWORK.



The outcome report produced from the first-stage analysis helps to determine which outcomes are clearly inferior and which are clearly superior relative either to the prior time period or to the national sample. Therefore, the second stage (that of outcome enhancement) *starts* with those outcomes, termed target outcomes, identified for further investigation. By selecting target outcomes, providers can focus their attention and energies for quality improvement on those care behaviors that produced the target outcomes. Evaluating or investigating processes of care entails reviewing the care provided for those patients who contributed to the target outcomes. This review can take several forms, ranging from informal discussions and brainstorming with agency care providers to structured clinical record reviews.

The review process results in findings which in turn must be translated into recommendations for changing or reinforcing certain aspects of care provision. These need to be systematically documented in a written plan of action for each target outcome (usually only a few target outcomes are chosen because this can be an intensive effort). The plan of action needs to be thoroughly implemented and continually monitored, which requires a strong agency commitment to changing care behaviors for each target outcome.

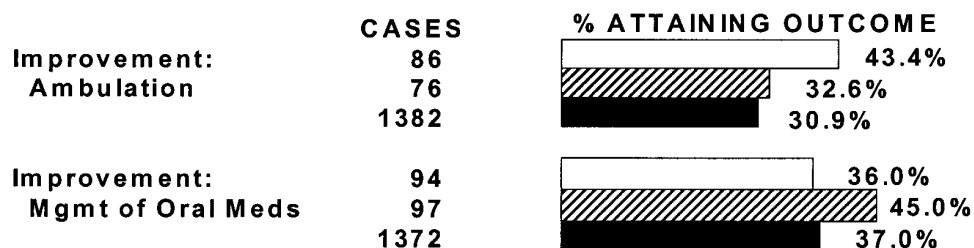
Subsequent outcome reports will indicate how well the care behavior changes have worked — in terms of patient outcomes. Thus, in reviewing its next outcome report, the agency should examine its target outcomes and the changes in those outcomes for their agency between the prior and current outcome reporting periods. Once OBQI is successfully implemented in an agency and becomes a “steady-state” activity, it emerges as a powerful agency tool to continuously improve care for the benefit of patients.

C. PURPOSES AND UTILITY OF UNIFORM DATA

For an agency whose leadership elects to implement data collection and data reporting for OASIS carefully and precisely (rather than simply meeting the Federal requirements), several exceptionally useful products will emerge. Three types of performance-related reports can be generated. First, as noted earlier, an annual report can be produced which compares an agency's outcomes to that of a national reference sample and to its outcomes for the prior year. An excerpt from an agency-specific outcome report is shown in Figure 3.2. Because the fundamental reason for providing home health care is to influence the well-being of patients, outcome reports reflect an agency's true bottom line from the perspective of the impact of care provided on patients' health. To be meaningful, such reports must be risk adjusted to take into consideration the difference between a given agency's case mix and the case mix of the comparison group (a national reference sample or the case mix of the same agency in the preceding year).

FIGURE 3.2: Excerpt - Outcome Report.

Functional Outcomes



KEY:  Current  Prior Period  National

The outcome report excerpt in Figure 3.2 presents results for two outcomes for the agency to which the report corresponds: improvement in ambulation and improvement in ability to manage oral medications. The numbers of patients on which findings are based for the current (i.e., this year's), prior (last year's), and national (reference) samples are given in the "CASES" column. The percentages of patients attaining the outcome for each group (current, prior, or national samples) are presented as bar graphs. In this illustration, the agency's performance was substantially better for the first outcome (improvement in ambulation) relative to both the preceding year and the national reference sample.² For the second outcome (improvement in ability to manage oral medications), the agency's performance dropped substantially from the preceding year but was approximately the same as the national reference sample.

Annual (or for larger agencies, more frequent) outcome reports can be generated for a number of clinical outcomes including physiologic, functional, cognitive, and mental health outcomes as well as utilization outcomes such as hospitalization, emergent care, and discharge to community. They can be generated for all patients or for specific types of patients (for example, over the past several years in the demonstration programs, over 80 outcomes have been used in generating risk-adjusted reports for all, orthopedic, and cardiac patients). For the purposes of "global" outcome measurement (i.e., for all patients), 41 outcome measures were selected for use in the national OBQI demonstration. These measures are presented in Table 3.1. The 41 outcomes in this table will form the starting point for CMS' outcome measures for OBQI. They were selected on the basis of both clinical and statistical criteria. In general, these outcomes meet the following criteria:

- They display sufficient variation within the home care patient population (i.e., they are neither extremely rare nor universally common).
- They can be affected by the care provided by a home care agency.
- They are amenable to risk adjustment (i.e., risk factors are readily measured and empirically demonstrate a statistical relationship with the outcome).

² In the actual reports on which Figure 3.2 and Table 3.2 are based, statistics are compared using significance tests. The significance levels for the differences are omitted in this chapter for ease of reading and to focus on principles rather than technical details.

- They reflect meaningful aspects of health status or quality of life for home care patients.

TABLE 3.1: OASIS-Based Outcome Measures Used in the National Medicare OBQI Demonstration.

End-Result Outcomes^a	
Improvement in grooming	Stabilization in housekeeping
Improvement in dressing upper body	Stabilization in shopping
Improvement in dressing lower body	Stabilization in phone use
Improvement in bathing	Stabilization in management of oral medications
Improvement in toileting	Improvement in speech or language
Improvement in transferring	Improvement in pain interfering with activity
Improvement in ambulation/locomotion	Improvement in number of surgical wounds
Improvement in eating	Improvement in status of surgical wounds
Improvement in light meal preparation	Improvement in dyspnea
Improvement in laundry	Improvement in urinary tract infection
Improvement in housekeeping	Improvement in urinary incontinence
Improvement in shopping	Improvement in bowel incontinence
Improvement in phone use	Improvement in behavioral problem frequency
Improvement in management of oral medications	Improvement in cognitive functioning
Stabilization in grooming	Improvement in confusion frequency
Stabilization in bathing	Improvement in anxiety level
Stabilization in transferring	Stabilization in speech or language
Stabilization in light meal preparation	Stabilization in cognitive functioning
Stabilization in laundry	Stabilization in anxiety level
Utilization Outcomes^a	
Any emergent care provided	Discharged to community
Acute care hospitalization	

^aEnd-result outcomes are health status outcomes. Utilization outcomes suggest but do not unequivocally reflect health status changes (and, as a result, can be regarded as proxy or surrogate outcomes).

As a second performance-related report, the case mix report describes the characteristics, circumstances, disabilities, and diseases of patients admitted to an agency over the past 12 months relative to both a national case mix reference sample and the case mix of the agency during the preceding year. This can be helpful in allocating or reallocating staff, including possibly changing staff mix, because changing case mix from one year to the next may highlight the need for alternative staffing arrangements. As shown in the excerpt from the case mix report in Table 3.2, information on demographics, payer source, etc., are presented (about 150 items are contained in case mix reports). This information can be of value not only from the point of view of resource allocation but also for

areas such as marketing and striking a desired balance between managed care patients and nonmanaged care patients.

Third, a report that documents selected untoward or negative events for an agency's patients can be produced (no illustration of this report is presented here). For example, in the various demonstration programs, such a report is produced for each agency describing the number and the percentage of patients receiving emergent care for falls and several similar measures. In addition, agencies receive a list of all patients experiencing each untoward event. This permits agency staff to investigate the clinical records for these patients in order to determine whether the untoward event may have been avoidable with more appropriate care.

TABLE 3.2: Excerpt from Case Mix Profile.

All Patients' Case Mix Profile at Start of Care					
	<u>Agency Mean</u>	<u>Reference Mean</u>		<u>Agency Mean</u>	<u>Reference Mean</u>
Demographics			Integumentary Status		
Age (average in years)	69.6	72.8	Presence of wound/lesion (%)	25.3%	30.9%
Gender: Female (%)	61.6%	63.5%	Surgical wound(s) present (%)	18.5%	22.8%
•	•	•	•	•	•
Payment Source			Elimination Status		
Any Medicare (%)	68.0%	82.1%	Incontinent day and night (%)	9.6%	9.5%
Any HMO (%)	17.4%	14.5%	Urinary catheter (%)	3.6%	5.8%
•	•	•	•	•	•
Current Living Situation			Acute Conditions		
Lives alone (%)	27.4%	29.5%	Orthopedic (%)	28.8%	21.5%
With other family member (%)	21.7%	27.5%	Cardiac/peripheral vascular (%)	15.0%	30.6%
•	•	•	•	•	•
ADL Disabilities at SOC			Chronic Conditions		
Grooming (0-4, scale avg.)	0.79	0.85	Dependence in personal care (%)	17.1%	22.5%
Dress upper body (0-2, scale avg.)	0.57	0.58	Dependence in med. admin. (%)	37.7%	39.4%
•	•	•	•	•	•
Respiratory Status			Diagnoses For Which Patients Are Receiving Home Care		
Dyspnea (0-4, scale avg.)	1.04	1.19	Neoplasms (%)	6.8%	9.3%
•	•	•	Respiratory system diseases (%)	11.4%	13.8%
•	•	•	•	•	•
Neuro/Emotional/Behavioral Status					
Moderate cognitive disability (%)	10.0%	12.3%			
Severe anxiety level (%)	10.5%	11.6%			
•	•	•			
•	•	•			

As noted earlier, the original purpose of OASIS was to serve as the core data set for outcome-based quality improvement (OBQI). The OBQI approach entails collecting patient data on OASIS at regular intervals (at start of care and every 60 days until and including time of discharge). OASIS data are computerized, edited, and transmitted to a central source (the central source for Medicare is the State agency specified by CMS, while for other purposes, such as JCAHO accreditation under ORYX, this might be a measure system vendor, etc.). A risk-adjusted outcome report that compensates for case mix differences between the agency and comparison or benchmark group is then produced, completing the outcome analysis component of OBQI shown in Figure 3.1. As discussed, an agency selects certain target outcomes for improvement (most commonly this would be for remediation, but it can also be for reinforcement of care behaviors that produce exemplary outcomes). The care provided for the selected target outcomes is then evaluated using a variety of potential methods (the demonstration agencies used a range of innovative techniques for such evaluations). Upon completion of the evaluation, a plan of action is documented that specifies which care behaviors will be changed, how they will be changed, who will be responsible for monitoring the implementation of the change, and how the change process will be evaluated. As noted, this completes the preparation for the outcome enhancement component. Its impacts can be determined through the next outcome report by assessing whether the target outcomes actually were enhanced.

Figure 3.3 highlights the main features of the outcome management paradigm that OBQI offers. Note that this overall approach enables agencies to move into the domain of managing resources for the explicit purpose of being more cost effective. That is, in addition to quality improvement, OBQI is an important tool for an agency to have at its disposal in the context of the current and pending payment system changes. In this figure, the different typeface sizes are intentional. The magnitude of the typeface for each domain in the figure reflects progressively greater importance. Presently, the home care community, CMS, and others are almost totally preoccupied with OASIS. However, OASIS is by far the least important component of the outcome management paradigm. As indicated in Figure 3.3, after OASIS data are collected, they permit an evaluation of outcomes. This enables an agency to enhance outcomes in areas of inadequate performance, reinforce outcomes in areas of exemplary performance (including assessing how the same exemplary outcomes can be attained with fewer resources), and maintain outcomes where performance is adequate. In the context of managing outcomes in this way, resource allocation and management are naturally affected. Staffing patterns, as well as frequency of services, can be altered with a clear bottom-line assessment of the impacts of such alterations on what happens to patients. As this is done iteratively over a period of months and years, quality of care can be enhanced (as we have seen in our

demonstration programs) and care can be rendered more cost effective. In an era when we are experiencing considerably greater emphasis on outcomes and fewer dollars available from payers, this paradigm to managing outcomes and subsequently costs can be of considerable value to agencies.

FIGURE 3.3: The Outcome Paradigm.



FREQUENTLY ASKED QUESTIONS

- 1. What is the single most important thing for agencies to do as they implement OASIS?**

The single most important thing is to keep the value and utility of outcome information foremost in the agency. Agencies that implement OASIS with a clear view of how OBQI will work for them will be far ahead of those who do not.

- 2. I feel my agency's patient population is very unique. Will the outcome reports be able to take these patient characteristics into account?**

Your concern highlights the importance of risk adjusting the outcome reports – to take into consideration the difference between a given agency's case mix and that of the comparison group. Risk adjustment compensates or controls for the potential influence of case mix variables (i.e., risk factors) that can affect outcomes.

- 3. When will agencies begin to receive outcome-based quality improvement (OBQI) reports based on the data that will be submitted to the OASIS national repository? Once agencies start receiving these reports, how often will they come?**

The outcome or OBQI reports will focus on patient-centered changes in health status between two or more time points. Receipt of OBQI reports will begin no sooner than one year after the reporting of OASIS data begins. In order to be valid, at least one year's worth of accurate, complete data is necessary. After that, we expect that OBQI reports will continue to be generated no less than annually. CMS anticipates that OBQI reports will be of three types: 1) an annual report which compares an agency's outcomes to that of a reference sample and to its outcomes in the prior year (if applicable). This report must be risk adjusted to take into consideration the difference between a given agency's case mix and the case mix of the comparison group(s); 2) a case mix report that will describe the characteristics, circumstances, disabilities, and diseases of the patients admitted to the agency over the past 12 months and compare these findings to a national reference standard as well as the case mix of the HHA in the preceding year; and 3) an adverse event outcome report that documents selected untoward or negative events for an agency's patients.

FREQUENTLY ASKED QUESTIONS

- 4. Will CMS be analyzing outcome data for Medicare managed care patients using the OASIS data set? Will there be a comparison between regular Medicare and Medicare HMO patients?**

OASIS data, case-mix adjusted OASIS data and outcome reports will represent a significant advancement in the ability to ascertain and assess variations in the quality of home health care delivery between regional and subgroup populations, including patients under fee-for-service, capitated, and managed care delivery programs. Working with HHAs, States, and Peer Review Organizations, CMS intends to use this information to help home health care providers improve the quality and efficacy of home health services to all patients. CMS plans to make comparisons between home health patients in the regular Medicare program and those enrolled in Medicare health maintenance organizations available sometime in the future.